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Supreme Court of the United States

DAVID KING, ET AL., PETITIONERS,

v.

SYLVIA MATHEWS BURWELL, U.S. SECRETARY OF HEALTH AND HUMAN SERVICES, ET AL.

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE FOURTH CIRCUIT

BRIEF FOR NATIONAL ASSOCIATION OF COMMUNITY HEALTH CENTERS, AMERICAN COLLEGE OF PHYSICIANS, INC., AMERICAN NURSES ASSOCIATION, ASSOCIATION OF ASIAN PACIFIC COMMUNITY HEALTH ORGANIZATIONS, AND 23 STATE PRIMARY-CARE ASSOCIATIONS AS AMICI CURIAE SUPPORTING RESPONDENTS

DEANNE E. MAYNARD
BRIAN R. MATSUI
MARC A. HEARRON
Counsel of Record
MORRISON & FOERSTER LLP
2000 Pennsylvania Ave., N.W.
Washington, D.C. 20006
(202) 778-1663
MHearron@mofo.com

Counsel for Amici Curiae

JANUARY 28, 2015

COCKLE LEGAL BRIEFS (800) 225-6964
WWW.COCKLELEGALBRIEFS.COM

TABLE OF CONTENTS

Page

TABLE OF AUTHORITIES ii

INTEREST OF AMICI CURIAE 2

INTRODUCTION AND SUMMARY OF ARGUMENT 6

ARGUMENT 8

A. A Ruling For Petitioners Would Cause Millions Of Americans To Lose Their Health Coverage, Would Drive Up Premiums, And Would Almost Certainly Result In A Near Death Spiral 8

B. Community Health Centers Serve A Critical Role In Our Health-Care System And Would Suffer Significant Economic Damage, Producing A Reduction In Services And An Increase In Total Health-Care Costs, If The Affordable Care Act's Subsidies Were Eliminated 12

C. Congress Intended Community Health Centers To Play A Vital Role In Providing Care Under The Affordable Care Act And Did Not Intend Them To Lack Adequate Funding To Fulfill Their Purpose 19

D. Eliminating The Affordable Care Act's Subsidies Would Cause Grave Medical, Mental, And Financial Harm To Millions Of Other Patients As Well 22

CONCLUSION 24

TABLE OF AUTHORITIES

Page

STATUTES & RULES

42 U.S.C. § 254b 14, 15, 22

42 U.S.C. § 254b(a)(1) 12

42 U.S.C. § 254b(k)(3)(F) 13

42 U.S.C. § 254b(k)(3)(G)(iii) 13

42 U.S.C. § 1395m(o) 21

42 U.S.C. § 1396a(bb) 21

42 U.S.C. § 1397gg(e)(1)(E) 21

Affordable Care Act § 1302(g), 42 U.S.C. § 18022(g) 21

OTHER AUTHORITIES

Linda J. Blumberg et al., *The Implications of a Supreme Court Finding for the Plaintiff in King vs. Burwell: 8.2 Million More Uninsured and 35% Higher Premiums* (Jan. 2015) ... 9, 10, 11, 13

Christine Eibner & Evan Saltzman, *Assessing Alternative Modifications to the Affordable Care Act: Impact on Individual Market Premiums and Insurance Coverage* (2014) 10, 11

Leighton Ku et al., *Strengthening Primary Care to Bend the Cost Curve: The Expansion of Community Health Centers Through Health Reform* (June 30, 2010) 19, 21

TABLE OF AUTHORITIES – Continued

Page

NACHC, *A Sketch of Community Health Centers: Chart Book December 2014* 17

NACHC, *Community Health Centers Lead the Primary Care Revolution* (Aug. 2010) 17, 18

Peter Shin et al., *Assessing the Potential Impact of the Affordable Care Act on Uninsured Community Health Center Patients: A Nationwide and State-by-State Analysis* (Oct. 16, 2013) 15

U.S. Dep't of Health & Human Servs., Health Res. & Servs. Admin., *The Affordable Care Act and Health Centers* (2014) 18, 20

BRIEF FOR NATIONAL ASSOCIATION OF COMMUNITY HEALTH CENTERS, AMERICAN COLLEGE OF PHYSICIANS, INC., AMERICAN NURSES ASSOCIATION, ASSOCIATION OF ASIAN PACIFIC COMMUNITY HEALTH ORGANIZATIONS, AND 23 STATE PRIMARY-CARE ASSOCIATIONS AS AMICI CURIAE SUPPORTING RESPONDENTS[1]

The National Association of Community Health Centers, the American College of Physicians, Inc., the American Nurses Association, the Association of Asian Pacific Community Health Organizations, the Alaska Primary Care Association, the Arizona Alliance for Community Health Centers, the Bi-State Primary Care Association, the Community HealthCare Association of the Dakotas, the Florida Association of Community Health Centers, the Indiana Primary Health Care Association, the Illinois Primary Health Care Association, the Iowa Primary Care Association, the Louisiana Primary Care Association, the Maine Primary Care Association, the Mississippi Primary Health Care Association, the Missouri Primary Care Association, the Montana Primary Care Association, the Health Center Association of Nebraska, the

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[1] Letters from the parties providing blanket consent to the filing of amicus briefs are on file with the Clerk of the Court. No counsel for a party authored this brief in whole or in part and no party or counsel for a party made a monetary contribution intended to fund the preparation or submission of the brief. No person other than amici curiae, their members, or their counsel made a monetary contribution to the preparation or submission of this brief.

North Carolina Community Health Association, the Pennsylvania Association of Community Health Centers, the South Carolina Primary Health Care Association, the Tennessee Primary Care Association, the Association for Utah Community Health, the Virginia Community Healthcare Association, the Wisconsin Primary Care Association, and the Wyoming Primary Care Association respectfully submit this brief as amici curiae in support of respondents.

INTEREST OF AMICI CURIAE

Amici are a broad coalition of physicians, nurses, and health centers who provide health care to patients throughout the Nation. Amici's members and their patients will be directly affected by this Court's decision. With the enactment of the Patient Protection and Affordable Care Act, amici's members added to their patient rolls millions of individuals and families who now have private health insurance purchased on federally operated exchanges with the assistance of tax credits. Amici therefore have a unique perspective on the impact of the Affordable Care Act and the issues affecting access to quality health care.

The Affordable Care Act is a significant achievement for the patients that amici's members serve, because it ensures greater protection against losing or being denied health-insurance coverage and promotes better access to primary care and to wellness and prevention programs. The Affordable Case Act's tax-credit subsidies are critical to achieving such access.

The Affordable Care Act's goal of optimizing health-insurance coverage for the greatest number of people permits health-care professionals to place their attention on the most important thing—the patient's well-being and healing—rather than on economic considerations. It also results in better health for patients and lower costs for society, as patients who put off needed care due to lack of insurance often end up sicker and require costlier care.

Amici curiae are as follows:

The **National Association of Community Health Centers ("NACHC")** is the national membership organization for federally qualified community health centers throughout the country. NACHC is a Section 501(c)(3) tax-exempt organization. Currently, more than 1,200 health-center organizations with more than 9,000 sites serve nearly 22 million patients nationwide. Of these organizations, 66% are located in the 37 States in which federal exchanges are currently in operation. In those 37 States, health centers operate more than 5,600 sites and are serving more than 12 million people, the vast majority of whom have incomes below 200% of the federal poverty level.

Community health centers are on the front lines of providing primary care for patients enrolled in health insurance through the Affordable Care Act exchanges. As a result of expansions to community health centers through funding provided by the

Affordable Care Act, community health centers now serve:

- 1 in 7 Medicaid beneficiaries,
- 1 in 7 uninsured persons,
- 1 in 5 low-income, uninsured persons,
- 1 in 3 individuals with incomes below the federal poverty level,
- 1 in 3 minority individuals below the federal poverty level,
- 1 in 3 children below the federal poverty level, and
- 1 in 7 Americans living in rural areas.

The **American College of Physicians, Inc. ("ACP")** is a national organization of internists—physician specialists who apply scientific knowledge and clinical expertise to the diagnosis, treatment, and compassionate care of adults across the spectrum from health to complex illness. ACP is the largest medical-specialty organization and second largest physician group in the United States. Its membership of 141,000 includes internists, internal-medicine subspecialists, and medical students, residents, and fellows.

The **American Nurses Association ("ANA")** represents the interests of the Nation's 3.1 million registered nurses. With members in every State, ANA is comprised of state nurses associations and individual nurses. In addition to its own membership of approximately 175,000 registered nurses, ANA's 35 organizational affiliates represent over 300,000 registered nurses. ANA is an advocate for quality

health care and the protection of rights that support appropriate care. ANA's members work throughout the continuum of care and in all settings within the health-care industry—from direct care to hospital administration.

The **Association of Asian Pacific Community Health Organizations ("AAPCHO")** is a national not-for-profit association of 35 community-based health-care organizations, dedicated to promoting advocacy, collaboration, and leadership that improves the health status and access of Asian Americans, Native Hawaiians, and other Pacific Islanders in the United States, its territories, and its freely associated states. AAPCHO advocates for policies and programs that improve the provision of health-care services that are community driven, financially affordable, linguistically accessible, and culturally appropriate.

The **23 amici state health-care associations** are statewide or bi-state nonprofit primary-care associations, comprised primarily of federally qualified community health centers. Their missions and goals include assisting health centers in the provision of primary-care services to low-income individuals and families residing in medically underserved areas. Each amicus primary-care association is located in and serves health centers in a State in which the federal government has established and operates a federal exchange under the Affordable Care Act.

INTRODUCTION AND SUMMARY OF ARGUMENT

The Affordable Care Act's tax credits have enabled millions of previously uninsured Americans to purchase private health insurance through exchanges—both those established by States and those established by the federal government. If this Court were to hold that these subsidies are available only in States that have set up their own exchanges, the consequences would be devastating. Over 8 million individuals would be unable to maintain their coverage. Over 90% of individuals and families earning under 200% of the federal poverty level would return to the ranks of the uninsured. As these individuals leave the market, the average per-person premium for everyone on the individual market would soar by at least 35%—almost assuredly resulting in a near "death spiral" in the individual insurance market in 37 States. The profoundly dire consequences of a ruling in favor of petitioners cannot be understated.

Among the most severely affected would be patients of community health centers. Community health centers provide primary care for the Nation's most medically underserved populations. Health centers also provide crucial services such as dental, vision, mental-health, transportation, and translation services. Community health centers have provided high-quality, efficient care for low-income people for many years, funded in part by grants from the federal government.

If this Court were to hold that subsidies are unavailable for insurance policies in the 37 States at issue, community health centers would face a funding crisis. Health centers have expanded to treat new patients, relying on payments from private insurance policies purchased with subsidies on the exchanges. Although many patients would lose their private insurance coverage, they would still be able to seek care from community health centers because, by law, health centers must treat all patients, regardless of ability to pay. Health centers would therefore have hundreds of thousands of patients that they must treat without adequate funding.

Accordingly, as a result of a ruling for petitioners:

- more than 90% of community health centers' patients who have obtained private insurance through subsidies would lose coverage;
- health centers would continue treating these patients but with a nearly $500 million shortfall;
- health centers would be forced to cut back on the scope of services they provide;
- patients would see delays in receiving service;
- patients would seek care from higher-cost providers (such as emergency departments), thereby driving up the overall cost of health care; and

- health-center staff likely would be laid off, thereby harming the economies in already-disadvantaged communities.

These results are not what Congress intended when it enacted the Affordable Care Act. On the contrary, Congress intended and specifically provided for community health centers to play an integral role in implementing the law. Congress allocated $11 billion to expand health centers to accommodate the newly insured and many remaining uninsured. Congress also enacted provisions requiring private insurers to pay health centers for treating patients who purchased insurance on the exchanges. None of these provisions turned on whether the patient lives in a State that implemented an exchange on its own or allowed the federal government to do so. It would have made no sense for Congress to have invested heavily in expanding and building new community health centers only to have them financially hobbled by having to treat millions of new patients who could not afford insurance without subsidies. The decision below should be affirmed.

ARGUMENT

A. A Ruling For Petitioners Would Cause Millions Of Americans To Lose Their Health Coverage, Would Drive Up Premiums, And Would Almost Certainly Result In A Near Death Spiral

If this Court were to rule that the Affordable Care Act's tax credits are available only to individuals

who purchase coverage through state-run exchanges, the effect would be devastating for the health and financial security of millions of individuals and families. This includes many individuals who currently receive health care from the Nation's community health centers.

To put it starkly, a decision for the petitioners would cause 9.3 million people in 37 States to lose tax credits that are used to purchase private health insurance. As a result, 8.2 million people would lose their health insurance altogether. This would represent a 44% increase in the number of uninsured in these States. Linda J. Blumberg et al., *The Implications of a Supreme Court Finding for the Plaintiff in King vs. Burwell: 8.2 Million More Uninsured and 35% Higher Premiums* at 1 (Jan. 2015).[2]

For the vast majority of individuals earning between 100% and 400% of the federal poverty level, the cost of insurance without tax credits would be prohibitive. It is estimated that only 4.5 million people would purchase health insurance from the individual (i.e., non-employer) market in these States, as opposed to the 14.2 million people who currently are enrolled through the individual market. *Id.* at 4. The number of people who would remain on the individual market—4.5 million—is even *fewer* than the 7.3 million people who purchased health insurance

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[2] http://www.urban.org/UploadedPDF/2000062-The-Implications-King-vs-Burwell.pdf.

on the individual market before the Affordable Care Act was implemented. *Id.* at 3-4.

The most vulnerable would be hit hardest. Out of those individuals and families earning under 200% of the federal poverty level, 91% would lose health insurance. *Id.* at 4. For those earning 200%-300% of the federal poverty level, 83% would lose health coverage, and 76% of those earning 300%-400% would lose coverage. *Ibid.*

There also would be 500,000 fewer children covered under Medicaid and the Children's Health Insurance Program ("CHIP"). *Ibid.* That is because, without tax credits, fewer parents would seek health-insurance coverage through exchanges, and consequently fewer children would be identified as eligible for public health insurance during their parents' or family members' enrollment process. *Ibid.*

The loss of subsidies for these individuals and families would dramatically drive up the cost of health insurance for *everyone* in the individual marketplace—even those who are ineligible for tax credits. One study estimates that, in 2016, the average per-person premium would soar by 35%, from approximately $4,100 to approximately $5,600. *Id.* at 6. Another study predicts premiums would rise by 43%. Christine Eibner & Evan Saltzman, *Assessing Alternative Modifications to the Affordable Care Act: Impact on Individual Market Premiums and Insurance*

Coverage at 20 (2014).[3] As a result, 42% of individuals and families with incomes more than 400% of the federal poverty level would lose their health insurance. Blumberg, *supra*, at 4. Enrollment in the individual market would decline by 68%. Eibner, *supra*, at 20.

The jump in premiums would occur because those most likely to drop health coverage first would be disproportionately lower-risk individuals. *Id.* at 20, 25. Individuals with higher risk are more likely to enroll regardless of whether they are eligible for tax credits. *Id.* at 20. Because of the change in the risk pool, a market without tax credits would have much higher premiums and would consequently price out most of the high-risk individuals who need coverage the most. *Ibid.* The effect would be "a near death spiral—that is, sharp premium increases and drastic enrollment declines in the individual market." *Id.* at 25.

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[3] http://www.rand.org/content/dam/rand/pubs/research_reports/RR700/RR708/RAND_RR708.pdf.

B. Community Health Centers Serve A Critical Role In Our Health-Care System And Would Suffer Significant Economic Damage, Producing A Reduction In Services And An Increase In Total Health-Care Costs, If The Affordable Care Act's Subsidies Were Eliminated

Patients of community health centers would be among the most affected by a ruling for petitioners. For the past 50 years, community health centers have provided community-based, efficient, and cost-effective primary-care services to low-income, underserved individuals throughout the United States. Community health centers fall into four general categories: (1) those serving medically underserved areas, (2) those serving homeless populations within a particular community or geographic area, (3) those serving migrant or seasonal farmworker populations within a particular geographic area, and (4) those serving residents of public housing. 42 U.S.C. § 254b(a)(1). Currently, more than 1,200 health centers serve nearly 22 million patients nationwide. Approximately 66% of health centers are located in States in which the federal government has established the health-insurance exchange. In those States alone, community health centers serve more than 12 million people.

Approximately 93% of all health-center patients have incomes below 200% of the federal poverty line, which makes them eligible for subsidies. Based on a 2014 survey conducted by NACHC and the George Washington University (the results of which are not

yet publicly available), approximately 1.4 million patients of community health centers are enrolled in health insurance through exchanges established under the Affordable Care Act. Approximately 745,000 of those individuals were enrolled through exchanges run by the federal government. (This number is actually higher today, as additional patients are being enrolled through the exchanges during the November 15, 2014 to February 15, 2015 open-enrollment period.) Patients who have health insurance through the exchanges must pay for the services they receive at the community health centers, through their insurance coverage. 42 U.S.C. § 254b(k)(3)(F). But more than 90% of those patients—i.e., at least 670,000—are expected to be unable to afford to maintain their health-insurance enrollment if this Court were to rule for petitioners. *See* Blumberg, *supra*, at 4.

To be sure, if this Court were to rule for petitioners, patients who would lose their insurance would be able to continue to seek health care from community health centers, despite the loss of insurance coverage. But the amount and scope of care they would be able to receive is likely to deteriorate. To be eligible to receive grants from the federal government, community health centers must offer services to all persons in their area, regardless of one's ability to pay. 42 U.S.C. § 254b(k)(3)(G)(iii). But because patients would no longer have health insurance, and because most of them are indigent, community health centers

would no longer be paid for the services that they provide these patients.

The costs that community health centers would have to bear if these patients lose insurance coverage en masse are staggering. In 2013, a health center's average cost per patient was $720.89. This per-patient figure is likely significantly underestimated for 2015, as many of the individuals who became health-center patients after 2013 were previously uninsured and therefore are likely to be sicker and more costly to care for than other patients. Nevertheless, using the 2013 per-patient figure, if nearly 700,000 patients currently enrolled in coverage through federally run exchanges lose their coverage but continue to receive primary care from community health centers, the centers would incur nearly $500 million in outlays that would no longer be covered.

Although community health centers do receive federal grants under Section 330 of the Public Health Service Act (42 U.S.C. § 254b), these funds would not be nearly enough to maintain the same scope of services for the patients who would lose their health insurance under a ruling for the petitioners. Indeed, the Section 330 grants are necessary for a different purpose: providing care for the populations that remained uninsured after the enactment of the Affordable Care Act. Based on health centers' experience in general—and specifically their experience in Massachusetts when that State implemented statewide marketplace coverage in 2006—health centers are unlikely to see any substantial decline in

the number of these previously uninsured patients. In Massachusetts, for example, after implementation of the health-reform law in 2006, the number of uninsured patients treated by community health centers actually *increased* by 6% between 2007 and 2011. Peter Shin et al., *Assessing the Potential Impact of the Affordable Care Act on Uninsured Community Health Center Patients: A Nationwide and State-by-State Analysis* at 6 (Oct. 16, 2013).[4] Thus, if Affordable Care Act tax credits were eliminated, health centers would have to use their Section 330 grants to provide care for both their already uninsured patients as well as patients who would become uninsured as a result of this Court's ruling.

The results of having to forgo payments from insurance coverage would be dire. Although health centers must continue to treat all comers, the level of service would deteriorate. Many community health centers in States that did not establish state-run exchanges already have a funding shortfall because these same States rejected an expansion of their Medicaid programs, which resulted in millions of indigent patients remaining uninsured. Although care for millions of patients with incomes below 133% of the federal poverty line was intended to be paid for by Medicaid, community health centers have had to continue treating these patients without Medicaid payments.

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[4] http://publichealth.gwu.edu/sites/default/files/GG%20uninsured%20impact%20brief.pdf.

If this Court rules for petitioners—causing health centers' patients to lose private insurance—health centers predictably would have to curtail even further the amount, duration, and scope of service they provide all their patients. Patients will have to wait to receive treatments because of these reductions in services. Many of the non-medical services that are hallmarks of community health centers will be cut. These services include dental, vision, and mental-health services, as well as other services that are important to indigent populations, such as translation services, transportation services, and tobacco-cessation classes. It would not be surprising if some health centers become insolvent and are forced to shutter their doors completely.

The quality of care provided to patients of community health centers also would decline because of the difficulty in obtaining specialist care for these individuals. Community health centers are primary-care facilities; when a serious medical condition requiring the care of a specialist arises, patients generally must seek such care outside the health center. Because most patients are indigent and uninsured, specialty referrals have been an ongoing problem for health centers and their patients. Private insurance coverage under the Affordable Care Act has greatly alleviated this problem. But if subsidies are removed and patients lose private coverage, they may be unable to access necessary, specialized care in the event of a serious medical condition.

Although it would seem that eliminating subsidies would decrease overall expenditures on health care, it actually would result in *more* expense. Community health centers are able to provide primary and preventive care at a vastly lower cost than other facilities from which uninsured individuals often seek care (e.g., hospital emergency departments). Providing care through community health centers saves $1,263 per patient per year. NACHC, *A Sketch of Community Health Centers: Chart Book December 2014* at Figure 6.1.[5]

Compared with other patients, patients of health centers have 18% lower rates of emergency-room visits, 64% lower rates of multi-day, inpatient hospital admissions, and 25% fewer total days spent in inpatient hospital care. NACHC, *Community Health Centers Lead the Primary Care Revolution* at 3 (Aug. 2010).[6] Communities served by health centers have fewer avoidable emergency-room visits than communities without health centers. *Ibid.* Communities with health centers spend $926 less per Medicare beneficiary than areas without community health centers. NACHC, *Sketch of Community Health Centers*, *supra*, at Figure 6.2. Thus, if subsidies are eliminated and access to care from community health centers curtailed, it not only would harm patients and health centers, it would drive up costs for everyone.

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[5] http://www.nachc.com/client/Chartbook_December_2014.pdf.

[6] http://www.nachc.com/client/documents/Primary_Care_Revolution_Final_8_16.pdf.

Removing subsidies also would harm the economies of States with federally established exchanges. The expansion of community health centers in the Affordable Care Act created hundreds of thousands of jobs. Nationwide, community health centers employ more than 156,000 individuals, more than 43,000 of whom have been added in the past five years. U.S. Dep't of Health & Human Servs., Health Res. & Servs. Admin., *The Affordable Care Act and Health Centers* at 1 (2014).[7] Because these jobs are usually in economically challenged areas, they act as a catalyst for economic revitalization, creating a "ripple effect" of economic activity in communities. NACHC, *Community Health Centers Lead the Primary Care Revolution*, *supra*, at 4.

Health centers provide critical entry-level jobs, training, and career-development opportunities for individuals in disadvantaged communities. The centers and their employees also spur economic growth by spending money at local businesses. All told, in 2015, health centers are expected to generate $53.9 billion in total economic activity (compared with $20 billion before enactment of health-care reform) and are estimated to have created an additional 285,000 full-time-equivalent jobs due to the Affordable Care Act. *Ibid.*

Because eliminating subsidies would significantly reduce private-insurance funding for community

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[7] http://bphc.hrsa.gov/about/healthcenterfactsheet.pdf.

health centers, many centers would be forced to lay off employees and/or reduce hours. And the already-disadvantaged communities in which health centers are located would feel a negative ripple effect. Many of the economic boosts generated by the Affordable Care Act would thus be eliminated by a ruling for petitioners.

C. Congress Intended Community Health Centers To Play A Vital Role In Providing Care Under The Affordable Care Act And Did Not Intend Them To Lack Adequate Funding To Fulfill Their Purpose

Congress did not intend the disastrous effects on community health centers and their patients that would inevitably result from removing subsidies in States in which the federal government has implemented healthcare exchanges. Far from that, Congress intended to establish a robust network of community health centers that would provide efficient, effective primary care. Indeed, community health centers were always intended to play a crucial role in implementing the Affordable Care Act.

One of the key concerns during the debate over health-care reform was whether the existing health-care system had sufficient capacity to manage the large increase in demand for services that was certain to occur once millions more Americans obtained affordable health insurance. Leighton Ku et al., *Strengthening Primary Care to Bend the Cost Curve: The Expansion of Community Health Centers*

Through Health Reform at 2 (June 30, 2010). Because of this concern, Congress provided a considerable investment in building, expanding, and upgrading community health centers in underserved areas. The Affordable Care Act established the Community Health Center Fund, and Congress allocated $11 billion in funding for the years 2011 to 2015. Out of that amount, $9.5 billion was targeted for creating new health centers for communities in need and for expanding preventive and primary health care services at existing centers, including oral health, behavioral health, pharmaceutical assistance, and enabling services. HRSA, *The Affordable Care Act and Health Centers, supra*, at 2. The remaining $1.5 billion was allocated to existing health centers, to allow them to modernize their aging facilities and to serve more patients. *Ibid.*

Health centers are especially vital to the Affordable Care Act's implementation because of their efficiency in providing high-quality service. Indeed, expansion of health centers is one of the key ways that the Affordable Care Act has managed to "bend" the cost curve—i.e., to dramatically lower the rise in per-capita health-care costs. Although care provided at community health centers is less expensive than care provided in other locations, "[h]ealth center quality of care equals and often surpasses that provided by other primary care providers." *Id.* at 1. The Affordable Care Act's expansion of community health centers was expected to save up to an additional $122 billion in total health-care costs between 2010

and 2015, and up to $316 billion between 2010 and 2019. Ku, *supra*, at 8. These amounts are above and beyond the cost savings that health centers already were providing.

Congress also established mechanisms to provide funding for the additional patients that would be seen by the new and existing community health centers. Before the Affordable Care Act, Congress amended the Medicaid Act to mandate that federally qualified community health centers be paid on a per-visit basis for the reasonable costs of treating Medicaid patients. 42 U.S.C. § 1396a(bb). In the Affordable Care Act, Congress provided for expansion of Medicaid eligibility to all individuals earning up to 133% of the federal poverty level, intending that health centers would be paid through Medicaid for treating the newly expanded Medicaid-eligible population. With respect to the non-Medicaid-eligible population, the Affordable Care Act provided that private insurers must pay community health centers per-service rates that are no less than the Medicaid rates. Affordable Care Act § 1302(g), 42 U.S.C. § 18022(g). In 2009, Congress also amended the CHIP program to require that community health centers be paid Medicaid rates for providing services to the CHIP-insured population. 42 U.S.C. § 1397gg(e)(1)(E). Moreover, the Affordable Care Act added payment for preventive services to the Medicare payment rate and eliminated an outdated cap on Medicare payments to health centers. *Id.* § 1395m(o).

By enacting all of these funding mechanisms, Congress envisioned that most of the new patients of community health centers would have some source of funding apart from the health center's Section 330 grant—whether through Medicare, Medicaid, CHIP, or private insurance. This scheme would ensure that health centers could expand, take on millions of new patients, and use their existing Section 330 grants to continue to treat the remaining uninsured population.

Significantly, this funding structure is incompatible with petitioners' view of the Affordable Care Act's tax-credits provision. Congress chose to spend billions of dollars to expand community health centers throughout the Nation, regardless of whether the State in which the health center is located decided to establish an exchange or to allow the federal government to do so. Yet under petitioners' theory, Congress tied the funding mechanism for treating patients in the private, individual marketplace to whether the State opted to set up an exchange. There is no reason to believe that Congress would have outlaid the funds to establish new and expanded community health centers while risking those centers' economic vitality by not providing payment for the new patients through private health insurance paid for with tax credits.

D. Eliminating The Affordable Care Act's Subsidies Would Cause Grave Medical, Mental, And Financial Harm To Millions Of Other Patients As Well

The disastrous consequences of eliminating the Affordable Care Act's tax credits would by no means

be limited to patients of community health centers. Millions of other patients treated by members of amici American College of Physicians, Inc. and American Nurses Association also would be seriously harmed. That was not Congress's intent.

By ensuring that patients are enrolled in a health-insurance plan, the Affordable Care Act (as currently implemented) allows enrollees to have a medical "home"—a place for regular care and a personal relationship with a clinician who ensures the delivery of preventive care and appropriate management of complex and chronic conditions. Such primary-care providers are able to coordinate a patient's care provided inside and outside the medical home, help patients understand their conditions, and coach them on healthy behaviors. Individuals with a primary-care provider can have conditions treated before they turn into a much more serious medical problem. Medical homes thus reduce the risk of new health-care problems, alleviate the need for high-cost, acute treatment, and lower the overall cost of care.

Amici have found that without health insurance, individuals often wait until a serious problem arises and then visit more expensive facilities, such as emergency departments, for treatment. They often lack access to routine preventive care to keep in check chronic, yet treatable, conditions such as high blood pressure or diabetes. Lacking health insurance thus puts low-income individuals' health at risk of serious harm.

It also threatens these individuals financially. Many low-income individuals without health insurance are simply a medical crisis away from personal bankruptcy. The lack of health insurance also exacts a toll on mental health, as having to manage one's health without the benefit of insurance is extremely stressful.

With the implementation of the Affordable Care Act, amici's members have seen the outlooks of countless patients transformed for the better. Amici's members on a daily basis see patients who have benefitted from the Affordable Care Act's provisions. It is critical to these patients' medical, mental, and financial health that they continue receiving tax credits so that they may continue purchasing private health insurance.

CONCLUSION

For the reasons set forth above and in respondents' brief, the Fourth Circuit's judgment should be affirmed.

Respectfully submitted,

DEANNE E. MAYNARD
BRIAN R. MATSUI
MARC A. HEARRON
Counsel of Record
MORRISON & FOERSTER LLP
2000 Pennsylvania Ave., N.W.
Washington, D.C. 20006
(202) 778-1663
MHearron@mofo.com

Counsel for Amici Curiae

JANUARY 28, 2015